GRACE RIDES

Office use only: Packet Receipt Date _____ Eval Date:_____

GRACE RIDES PARTICIPANT'S APPLICATION

First Name:_____ MI:___ Last Name:_____

Address(City/St/Zip):_____

Phone-Home:_____ Work:_____ Cell:_____ Text? Y N

E-Mail:_____ Occupation/School:_____

DOB:_____ Age:_____ Height:_____ Weight:_____ Gender: M F

Parent/Legal Guardian:_____ Phone:_____

Address(if diff from rider):_____

Emerg.Contact:_____ Relationship:_____ Ph:_____

How did you hear about us?_____

HEALTH HISTORY

Diagnosis: _____ Date of Onset:_____

Please indicate special needs in the following areas:

		Comments
Vision	Y N	
Hearing	Y N	
Sensation	Y N	
Communication	Y N	
Heart	Y N	
Breathing	Y N	
Digestion	Y N	
Elimination	Y N	
Circulation	Y N	
Emotion/Mental Health	Y N	
Behavioral	Y N	
Pain	Y N	
Bone/Joint	Y N	
Muscular	Y N	
Thinking/Cognition	Y N	
Allergies	Y N	

GRACE RIDES

MEDICATIONS

_____
_____
_____
_____

Please describe your abilities/difficulties in the following areas (include asst/eqpmt needed):

PHYSICAL FUNCTION (e.g. mobility skills such as transfers, walking, wheelchairs…)

_____
_____
_____
_____
_____

PSYCHOSOCIAL FUNCTION (e.g. work/school, grade completed, interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.…)

_____
_____
_____
_____
_____

GOALS (i.e. Why are you applying to participate? What do you want to accomplish?)

_____
_____
_____
_____
_____

Does rider have horse experience? (check one) None___ Some___ Much___

Tell Us About Your Experience:_____

_____
_____
_____

Signature:_____ Date:_____

Print Name:_____

PATH INTL MEMBER CENTER

GRACE RIDES, INC. 1560 HICKORY STREET, NICEVILLE, FL 32578
PHONE: 850-259-9195 SHERRY@GRACERIDES.COM
HTTP://WWW.GRACERIDES.COM

GRACE RIDES

CONSENT & LIABILITY WAIVERS

I have provided the information requested in this form accurately to the best of my knowledge. I know of no reason why I should not participate in the GRACE Rides program.

Signature:_____ Date:_____

Signature of Parent or Legal Guardian if participant is under age 18:

Signature:_____ Date:_____

Print Name:_____

LIABILITY RELEASE:

As a participant in the GRACE Rides program, I acknowledge the inherent risks and potential for risks of horses and a horseback riding program. However, I feel that the benefits to me are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, WAIVE AND RELEASE forever all claims for damages against the GRACE Rides program, its Board of Directors, instructors, therapists, volunteers, employees, owners/leasers of horses on property upon which GRACE Rides operates, and owners/leasers of property upon which GRACE Rides operates, and agree to hold harmless and indemnify the aforesaid parties, for any and all liability or responsibility for any accident, damage, injury, illness and/or losses that I, and any family member, guest or spectator accompanying the me as the undersigned, may sustain while on the property upon which GRACE Rides operates.

Signature:_____ Date:_____

Signature of Parent or Legal Guardian if participant is under age 18:

Signature:_____ Date:_____

Print Name:_____

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CODE OF CONDUCT:

GRACE Rides program participants are responsible for maintaining and promoting ethical practices to respect the dignity and well being of all animals and individuals. Any person will be asked to leave based upon irresponsible behavior, indecent mannerisms, profanity, or anti-social statements or actions. Safety procedures must be followed at all times. Mistreatment or abuse of persons, horses or other animals, use of alcohol and/or illegal drugs, use of fireworks, and use of tobacco (smoked or chewed), on the premises is strictly prohibited. Any incidence of behavior or activity in violation of these policies must be reported to the Executive Director immediately.

I, THE UNDERSIGNED, HAVE READ AND UNDERSTAND THE GENERAL RULES AND SAFETY PRECAUTIONS FOR PROGRAM PARTICIPANTS.

Signature:_____ Date:_____

Signature of Parent or Legal Guardian if participant is under age 18:

Signature:_____ Date:_____

CONFIDENTIALITY AGREEMENT:

I understand that all information (written and verbal, including without limitation any medical, social, referral, personal and/or financial information) that may be disclosed as a result of participation at GRACE Rides, with regard to any rider(s), volunteer(s), and their family(s), is confidential and will not be shared with anyone not associated with GRACE Rides without expressed written consent of the volunteer or participant and his/her parent/guardian in the case of a minor. Negative representation of the program in the community and/or failure to adhere to GRACE Rides confidentiality policy may result in termination from the program, and other corrective actions may be taken. Any person making negative representation(s) of the program and/or disclosing confidential information to others outside of the program agrees to completely indemnify GRACE Rides against all damage, loss, injury, and legal and other costs incurred as a result of such representation(s) and/or disclosure(s).

Signature:_____ Date:_____
Signature of Parent or Legal Guardian if participant is under age 18:

Signature:_____ Date:_____

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PHOTO RELEASE:

(please check): I ___DO ___DO NOT consent to and authorize the use and reproduction by the GRACE Rides program of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Signature:_____ Date:_____
Signature of Parent or Legal Guardian if participant is under age 18:

Signature:_____ Date:_____

Print Name:_____

PARENTS' QUESTIONAIRE:
Do you want or need to be involved with your rider's session? If so, please explain:

Would you like for your rider to participate in any of the following:
____ 4-H Club ____Publicity shoots/photos ____Special Olympics
____ Horse Shows ____Speaking Engagements ____Benefit Events

Do you want to volunteer for special events with any of the following:
____Providing refreshments ____Decorating ____Sponsorship
____Fundraising ____Silent Auction ____Sidewalking

CONSENT PLAN AND AGREEMENT FOR EMERGENCY MEDICAL TREATMENT:
In the event emergency medical aid/treatment is required due to illness or injury while being on the property and/or premises of GRACE Rides, I authorize the GRACE Rides program to: 1) Secure and retain medical treatment and transportation as needed, at my expense, and 2) Release records upon request to the authorized individual or agency involved in the medical emergency treatment. This authorization includes, x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life-saving" by the attending physician. This provision will only be invoked if the person(s) below is/are unable to be reached after reasonable effort under circumstances existing at the time of need.

Signature:_____ Date:_____
Signature of Parent or Legal Guardian if participant is under age 18:

Signature:_____ Date:_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Check one: ___Participant ___Staff ___Volunteer

Name:_____DOB:_____Phone:_____

Address:_____

Physician's Name:_____Medical Facility:_____

Health Insurance Co:_____Policy#:_____

Allergies to medications:_____

Current medications:_____

In event of an emergency, contact:

Name:_____Relation:_____Phone:_____

Name:_____Relation:_____Phone:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the program, I authorize GRACE Rides to:

1. Secure & retain medical treatment & transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date:_____ Consent Signature:_____

Client/Parent/Legal Guardian

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the GRACE Rides program. In the event emergency treatment/aid is required, I desire the following procedures to take place:_____

_____

_____

Date:_____ Consent Signature:_____

Client/Parent/Legal Guardian

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PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant:_____DOB:_____Phone:_____

Address:_____

Diagnosis:_____Date of Onset:_____

Past/Prospective Surgeries:_____

Medications:_____

Seizure Type:_____Controlled: Y N Date of Last:_____

Shunt Present: Y N Date of last revision:_____

Special Precautions/Needs:_____

_____

Mobility: Indep.Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices:_____

For Down Syndrome: AtlandoDens Interval X-Rays, Date:_____ Result: + -

Neurologic Symptoms of AtlantoAxial Instabiity:_____

Indicate needs in the following areas, including surgeries:

			Comments
AUDITORY	Y	N	_____
VISUAL	Y	N	_____
TACTILE SENSATION	Y	N	_____
SPEECH	Y	N	_____
CARDIAC	Y	N	_____
CIRCULATORY	Y	N	_____
INTEGUMENTARY/SKIN	Y	N	_____
IMMUNITY	Y	N	_____
PULMONARY	Y	N	_____

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NEUROLOGIC	Y N	_____
MUSCULAR	Y N	_____
BALANCE	Y N	_____
ORTHOPEDIC	Y N	_____
ALLERGIES	Y N	_____
LEARNING DISABILITY	Y N	_____
COGNITIVE	Y N	_____
EMOTIONAL	Y N	_____
PSYCHOLOGICAL	Y N	_____
PAIN	Y N	_____
OTHER	Y N	_____
	Y N	_____

Additional Comments/Recommendations:_____

_____

_____

_____

Given the above diagnosis and medical information, this person seeking to participate in equine-assisted therapy is not medically precluded from participation in such activities.

Print Name: _____ MD DO NP PA Other_____

Signature: _____ Date: _____

Address:_____

Phone: (_____)_____ License/UPIN Number:_____

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"I CAN DO ALL THINGS THROUGH CHRIST WHO STRENGTHENS ME." Phillipians 4:13

DONATION OPTIONS:

$_____ IN MEMORY/HONOR OF:_____

MONTHLY SPONSORSHIPS (Pay by 1st of each month):

BRONZE SPONSOR	$10 to $99
SILVER SPONSOR	$100 to $199
GOLD SPONSOR	$200 to $299
SAPPHIRE SPONSOR	$300 to $399
RUBY SPONSOR	$400 to $499
EMERALD SPONSOR	$500 to $599
DIAMOND SPONSOR	$600 to $749
PLATINUM SPONSOR	$750 and up

OTHER DONOR OPTIONS

BRONZE DONOR	$0 to $ 99
SILVER DONOR	$100 to $199
GOLD DONOR	$200 to $299
SAPPHIRE DONOR	$300 to $399
RUBY DONOR	$400 to $499
EMERALD DONOR	$500 to $599
DIAMOND DONOR	$600 to $749
PLATINUM DONOR	$750 and up

THERAPEUTIC SESSION (PER RIDER) SPONSORSHIP (approx 10 weeks each, 1 therapeutic lesson per week):

WINTER - $ 400 SPRING - $ 400 FULL ANNUAL - $ 1,600
SUMMER - $ 400 FALL - $ 400

THERAPY ANIMAL SPONSORSHIP:

EQUINE - $2,400 annually, $1,200 semi-annually or $200 per month

Your name will be listed on the animal's stall as sponsor. Check your choice:
___Cochise ___Cookie ___Flower ___Levi ___Magnum
___Puck ___Rain ___Sport ___Zacheus ___Any
Individual grooming time can be scheduled with your sponsored horse!

COMPANION ANIMAL - $ 300

___Cat Rudy ___Cat Annabelle ___Chicken Flock ___Bunny
___Goat Jase ___Goat Jep ___Goat Jasper ___Goat Willie

ANNUAL NAMING SPONSORSHIPS:

MAIN BARN -	$ 6,000
EAST BARN WING -	$ 4,000
ARENA -	$ 3,000
SENSORY ARENA -	$ 2,500
ROUND PEN -	$ 1,000

These funding options are available first come, first served for each year. Circle your choice. A plaque will be mounted on premises to reflect your sponsorship with the listed year.

Funds may be delivered to 1560 Hickory Street, Niceville, or mailed to 110 Sunset Cove, Niceville FL 32578. Funds may also be transmitted by paypal through our website.

NAME:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

PHONE NUMBER:_____ EMAIL ADDRESS:_____

SIGNATURE:_____

I AM ABLE AND WILLING TO VOLUNTEER TIME TO SERVE THE PROGRAM: Yes_____ No_____

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THANK YOU FOR YOUR GIFT OF ANY AMOUNT! YOUR HELP KEEPS OUR RIDER'S SITTING TALL IN THE SADDLE!

A receipt to evidence your total donation amount for tax purposes will be provided after each year's end.

501(c)3 Fed Public Charity #26-3084817 Fla. Dept. Agric & Consumer Svcs Registration #CH29085

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